Denver Health Referral Form

Fax completed referral form to: 720-956-2320

Please allow 2 business days for processing. For ***urgent requests***, please call the appointment center at 303-628-1550 after submitting the completed form.
***This form is not to be used for Radiology/Imaging ***

Patient Information	Referral Information
Name (First, Middle, Last) Sex: ☐ Male ☐ Female	Priority: Routine ☐ Urgent ☐ (call after submitting) Elective ☐
	If Urgent, please describe:
If child, name of parent:	
Date of Birth:	Diagnosis and/or ICD 10:
Phone # Secondary Contact #	Clinic / Specialty Requested:
Address	Clinical Question:
City Zip Code State	
Interpreter Needed? Yes ☐ No ☐ Preferred Language:	☐ Consultation ☐ Co-Management Shared Care ☐ Co-Management Principle Care ☐ Complete Transfer ☐ Procedure

Insurance Information:	
Insurance Carrier:	Member ID:
	Subscriber Name:

Referring Provider Information	
Referring Provider Name	Phone
Practice Name	Fax
Practice Address	Email
Practice City/State/Zip Code	NPI #
PCP Name	PCP Phone

Additional Documentation Included

☐ Relevant Clinical Notes (History & Physical, Imaging and Lab results)

EpicCare Link

Send and manage referrals online

https://epiccarelink.denverhealth.org